

Managing Pain in a Drug-Dependent Patient

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How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. REVIEW THE OBJECTIVES

The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. STUDY EACH SECTION IN ORDER

Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. COMPLETE THE COURSE EXAM

After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. GRADE THE TEST

Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. FILL OUT THE EVALUATION FORM

Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation.** At this point, you should print the certificate and keep it for your records.

Objectives

At the completion of this learning activity the learner will be able to:

- Describe the most commonly abused prescription drugs.
- Identify differences between tolerance, physical dependence, pseudoaddiction, and addiction.
- Identify the options available to those in recovery from substance abuse and to manage both acute and chronic pain.

Introduction

In 2001, the Joint Commission stated that effective pain management is a crucial component of good care. The standards mandated that all healthcare professionals are required to:

- Recognize the rights of patients to appropriate assessment and management of pain.
- Assess the existence, and if possible, the intensity of pain in all patients.
- Record the results of the assessment in a way that facilitates reassessment and follow-up.
- Determine and ensure staff competency in pain assessment and management, and address pain assessment that supports the appropriate prescription or ordering of effective pain medication.
- Educate patients and their families about effective pain management.
- Address patient needs for symptom management in the discharge process.

In order to assess and treat pain effectively, healthcare professionals need to educate themselves on the components of pain and certain sub-populations that they may encounter.

About the Author

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What is Pain?

Pain is a total biopsychosocial experience. It is experienced in three different realms:

1. Biological.
2. Psychological.
3. Social/cultural.

Biological pain (physical pain) is a signal that something is going wrong with your body. Pain helps us determine what is wrong, where the injury is located, and how severe the injury or illness is. All pain receptors are free nerve endings called nociceptors. There are mechanical, thermal and chemical pain receptors.

Mechanical pain receptors sense mechanical forces that displace or deform tissue. Thermoreceptors sense extreme heat and cold. Chemical pain receptors sense a change in H⁺, K⁺, histamine, acetylcholine, or oxygen deficiency. They are found in the skin and on internal surfaces such as the periosteum and joint surfaces. Deep internal surfaces are only weakly supplied with pain receptors and will propagate sensations of chronic, aching pain if tissue damage in these areas is experienced.

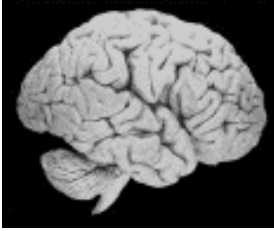
The perception of pain occurs when the nociceptors are stimulated and transmit signals through sensory neurons in the spinal cord. These neurons release glutamate, a major excitatory neurotransmitter that relays signals from one neuron to another. The signals are sent to the thalamus in which pain perception occurs. From the thalamus, the signal travels to the somatosensory cortex in the cerebrum, at which point the individual becomes fully aware of the pain.

There are two types of sensory nerve fibers that transmit signals that the brain interprets as pain:

- **A δ** ("A-delta") **fibers**
 - These are thinly-myelinated.
 - They transmit signals rapidly that are associated with **acute pain**. This is "good pain" because it warns you to do something to take care of the problems (e.g., a hot saucepan).
- **C fibers**
 - These are unmyelinated and thus conduct impulses slowly.
 - Their activation is associated with diffuse, dull, **chronic pain**. This is "bad pain" because it cannot be alleviated simply by removing the stimulus. It is pain generated by such things as damaged tissue or pain that remains after the stimulus that caused acute pain has been removed.
- Painless stimuli such as light touch are transmitted by a third class of neuron, the thickly-myelinated **A β** ("A-beta") **fibers**.

The *gate control theory of pain*, proposed by Patrick Wall and Ron Melzack, postulates that pain is "gated" by non-painful stimuli such as vibration. Thus, rubbing a bumped knee seems to relieve pain by preventing its transmission to the brain. Pain is also "gated" by signals that descend from the brain to the spinal cord to suppress (and in other cases enhance) incoming pain information. Some areas in the dorsal horn of the spinal cord that are involved in receiving pain stimuli from A δ and C fibers, called laminae, also receive input from A β fibers (Kandel, Schwartz, & Jessell, 2000). The non-nociceptive fibers indirectly inhibit the effects of the pain fibers, "closing a gate" to the transmission of their stimuli (Kandel et al., 2000).

Managing Pain in a Drug-Dependent Patient



Did you know?

The brain itself does not have pain receptors. In fact, most brain surgery is performed using a local anesthetic only. The meninges (the outer covering of the brain); however, are very sensitive to pain.

Psychological pain results from the meaning that the patient assigns to the pain signal. They psychologically react to the pain by thinking, feeling, and acting in certain ways. They may experience emotional reactions to the pain. They may become angry, frightened, or frustrated. Their reaction may be based on previous experiences with pain. It may lead to a refusal for pain medication or increased requests for pain medication.

Social/cultural pain results from the social and cultural meaning assigned by other people to the pain that is being experienced. Whether or not the pain is recognized as being severe enough to warrant a socially approved sick role may play a part in this. When a patient talks about their pain to family and friends, it helps them develop a social and cultural context for assigning meaning to their personal pain experience and taking appropriate action.

Cultural competence is described as a set of attitudes, beliefs, behaviors and policies that enable a person, agency or system to work effectively in multi-cultural, pluralistic, and linguistically diverse communities. Effective pain management is one area that is directly affected by one's cultural competence. Responses to pain culturally have been divided into two categories: emotive and stoic. Emotive patients are more likely to express their pain in ways that the health team understands. They are often of Hispanic or Latino, Middle Eastern and Mediterranean backgrounds. On the other hand, stoic patients keep their expressions of pain inside. These are those patients who "grin and bear it." They are often of Northern European and Asian backgrounds. Not paying attention to this dynamic can lead to ineffectual pain management and addiction problems.

Pain Relief

The body has several different types of opioid receptors that are activated in response to the binding of the body's endogenous endorphins. These receptors, which exist in a variety of areas in the body, inhibit firing of neurons that would otherwise be stimulated to do so by nociceptors. There are three major subtypes of opioid receptors: μ (*mu*), κ (*kappa*), and δ (*delta*). Opioid alkaloids such as morphine, codeine, and methadone bind to the μ -receptor. Activation of the μ receptor by an agonist such as morphine causes analgesia, sedation, reduced blood pressure, itching, nausea, euphoria, decreased respiration, miosis (constricted pupils) and decreased bowel motility often leading to constipation. Some of these effects, such as sedation, euphoria and decreased respiration, tend to disappear with continued use as tolerance develops.

To see an animated video of opiate receptors, go to:
<http://www.wnet.org/closetohome/animation/opi-anim2-main.html>.

Analgesia, miosis and reduced bowel motility tend to persist; little tolerance develops to these effects. Although tolerance to respiratory depression develops relatively quickly, it is the single most adverse side effect of opioid use; it is how overdoses kill. Opioid overdoses can be rapidly reversed with any of several opioid antagonists, such as Narcan, drugs that bind to the μ receptors more strongly than most agonists but do not activate them. This displaces the agonist drug, countering its effects.

Managing Pain in a Drug-Dependent Patient

Pain versus Suffering

While pain is a biological signal from your body, suffering is a subjective experience that results from the meaning or interpretation of the pain. It often results in irrational beliefs such as “I shouldn’t have pain” or “If I can’t manage this pain, there must be something wrong with me.” These feelings can cause guilt, shame, or even anger in the patient who is experiencing the pain. For a drug addict, these feelings can lead to a relapse.

Acute Pain versus Chronic Pain

Acute pain happens immediately and tells your mind something is wrong with your body. It usually comes from an easily identified source and there is a predictable healing process. Acute pain drives you to a source of relief, usually an analgesic or narcotic medication. Chronic pain lingers long after the initial injury (more than 6 months) and serves little to no useful purpose. The treatment of chronic pain is often frustrating because it fails to respond to standard medical interventions. Common examples of this type of pain are migraine headaches and back pain. Because of its duration, chronic pain can have a profound effect on the quality of life of a patient. It can lead to depression, anxiety, family problems, job loss, disability, finance troubles, and addiction.

Neuropathic pain is a type of chronic pain resulting from an injury or disorder affecting the peripheral or central nervous system. Examples include: diabetic neuropathy, post herpetic neuralgia, and post-thoracotomy syndrome. This pain is described very differently than other kinds of chronic pain. It is often described by patients as a burning, tingling, numbness, or a pain shooting down an arm or a leg. Pain management for these patients requires additional therapy that often includes: Neurontin, Cymbalta and Lidoderm patches (Elliot, Smith, Penny, Chambers, & Smith, 1999).

Statistics

In 1999, The International Association for the Study of Pain estimated that:

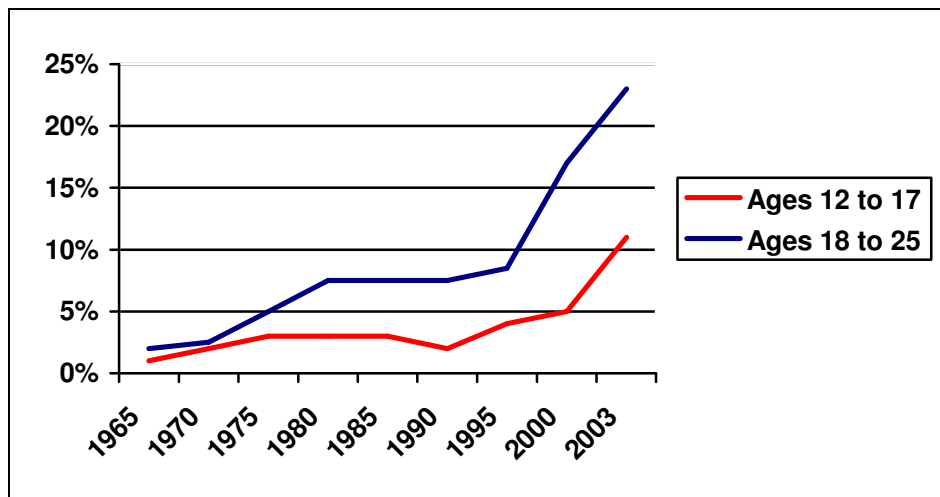
- Over 86 million Americans were suffering with chronic pain.
- Over 66 million were partially or totally disabled.
- 8 million were permanently disabled due to back pain.

Peter D. Hart Research Associates (2003) estimated that now over 117 million Americans are suffering from chronic pain.

Some research studies indicate that only 2% - 5% or less of people who take narcotic medication for chronic pain management either abuse or become addicted to their medications. Other studies estimate as high as 20-25% become addicted (Grinstead, 2007). In a 1992 literature review by Fishbain et al. (as cited in Fishbain et al, 2003), the prevalent percentages for drug abuse/dependence/addiction for patients with chronic pain was in the range of 3.2% to 18.9%. They cautioned that these results did not tap the concept of addiction and that the prevalence of addiction was likely at the lower end of this range due to the concept of pseudoaddiction.

In 2004, an estimated 31.8 million Americans have used prescription drugs non-medically in their lifetime. Older adults tend to be prescribed these meds three times more often as the general population. Men and women abuse prescription drugs at about the same rate, but women are 48% more likely to be prescribed abusable drugs. The most dramatic increase in misuse of prescription drugs is among adolescents age 12-25 (see Table 1).

Table 1. Percentage of 12-25 year olds using painkillers without a prescription.



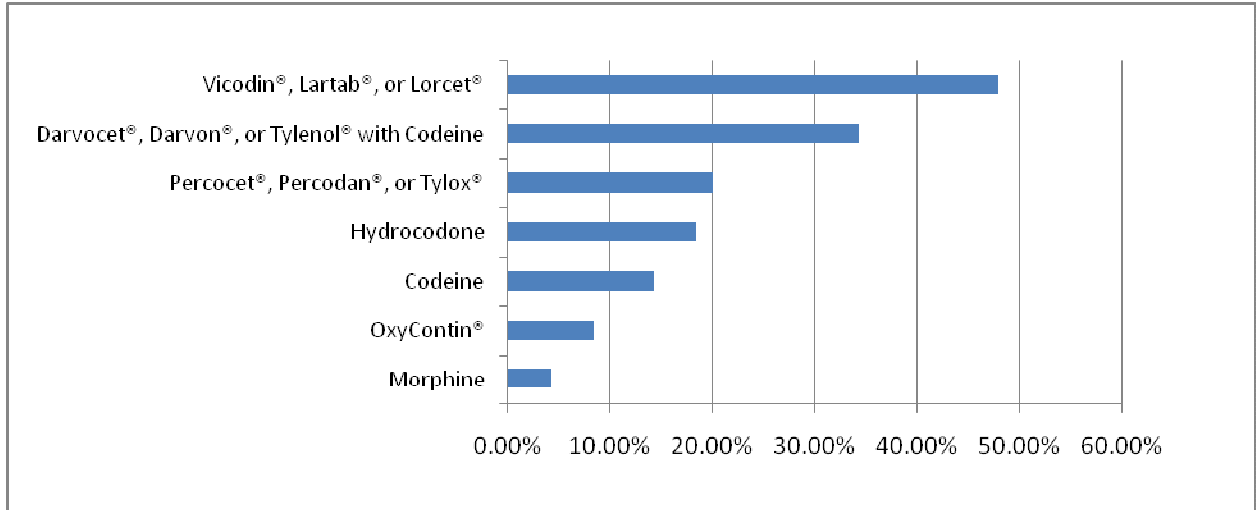
Source: National Survey on Drug Use and Health (2006)

The Substance Abuse and Mental Health Services Administration (SAMHSA) 2006 National Survey on Drug Use and Health found that 4 million young adults aged 18 to 25 (12.4%) used prescription pain relievers (analgesics), such as OxyContin, non-medically within the past year in 2005. In addition, 1.7% of the young adults met the criteria for dependence or abuse of prescription pain relievers in the past year. Lifetime misuse of OxyContin increased from 1.9 million to 3.1 million persons from 2002 to 2004 (see Table 2). Among the young adult non-medical users of pain relievers in the past year, 53% obtained the pain relievers that they last used non-medically from a friend or relative for free. Of those who met the criteria for prescription pain reliever dependence or abuse, they obtained their most recently used pain relievers from the

Managing Pain in a Drug-Dependent Patient

following sources: 37.5% obtained them for free from a friend or relative, 19.9% bought them from a friend or relative, and 13% obtained them from one doctor.

Table 2. Specific Types of Pain Relievers Used During the Past Year Among Initiates of Non-medical Use of Pain Relievers: 2004



Source: National Survey on Drug Use and Health (2006)

Pain Medications (Opioids)

Opioids, sometimes called narcotics, are natural compounds derived from the opium poppy. The primary purpose of these medications is to relieve pain, but they have a high potential for abuse. Frequently prescribed opioids include the following:

- Codeine
- Fentanyl (Duragesic)
- Hydromorphone (Dilaudid)
- Levorphanol (Levo-Dromoran)
- Meperidine (Demerol)
- Methadone (Dolophine)
- Morphine (MS Contin)
- Oxycodone (OxyContin, Percocet, Percodan, Endocet, Roxicet, Tylox)
- Oxymorphone (Numorphan)
- Propoxyphene (Darvon, Darvocet)
- Tramadol (Ultracet, Ultram)
- Carisoprodol (Soma)
- Hydrocodone (Vicodin, Lorcet, Lortab, Hydrocet, Anexisia, Co-gesic, Maxidone, Norco, Zydone, Tussionex)

Coming to Terms

The use of opioids can cause three processes in the patient and it is very important to be able to distinguish between them. The first is **tolerance** - a normal physiological response to sustained use of a substance. However, both the desired effects and the adverse effects lessen over time. This means that higher and higher doses of the medication are required to produce the same effect. Concurrently, side effects such as respiratory depression, sedation, and nausea also decrease (constipation and miosis do not decrease over time).

The second process that occurs is **physical dependence** - the body becomes used to the drug, and should the use of the medication be interrupted, then withdrawal symptoms will occur. This is not to be confused with *addiction*. If a patient is taking medication for analgesia, they will experience pain relief, not euphoria. However, withdrawal will still be experienced as the body now depends on the drug.

Withdrawal from opiates is a very painful process, with symptoms resembling a severe flu. The patient may experience muscle and bone aches, chills, insomnia, involuntary leg movements, nausea/vomiting, and diarrhea. This is rarely a life threatening process but can greatly interfere with a patient's ability to heal properly. Withdrawal protocols should be established by an addiction specialist and followed at all levels of care. Opioids can also produce what is sometimes described as "rebound pain." For instance, some opioids have an effect that lasts only a few hours. The pain can return as these short-acting medications wear off. Ironically, opioids can also cause changes in the nervous system that may actually heighten the perception of pain and make the patient feel MORE uncomfortable.

The stage beyond physical dependence is **addiction**, a disease marked by cravings for the drug and compulsive use of the drug despite repeated, harmful consequences. It is a neurobiological disease and drug addicts are unable to control his or her use of the drug. They are taking the medication for reasons other than pain relief.

Stigmatizing Patients as Addicts

“Drug seeking behavior” may often simply signify the need for more effective pain management. A common scenario that you may encounter is an Emergency Department (ED) visit by a patient suffering from migraine headaches, fibromyalgia, or sickle cell crisis. They request a specific analgesic or say they are allergic to all but one. Are they drug seeking? Or are they in tremendous pain and seeking relief? Some other scenarios you may encounter are:

- The patient who is a “frequent flyer,” visiting several EDs to obtain opioid analgesics.
 - If the treatment at one ED results in poor pain relief, the patient may go to another ED. Also, if their pain is not being controlled by their primary physician they may end up in the ED more often.
- The patient obtains opioids from more than one provider.
 - If their pain is relieved for most of the day by one pill, but the doctor will only prescribe 30 tablets every three months, the patient may seek another prescription from another physician.
- The patient requires higher doses of opioids than do other patients.
 - This is a sign of physical dependence and not necessarily addiction. A patient who has been taking opioids on a regular basis may require up to 100 times more opioid than an opioid-naïve patient (McCaffery, 2001).
- The patient “prefers the needle to the pill.”
 - The pain relief is likely to be much less with oral opioids than IV or IM. An oral dose may only give one-fifth to one-sixth the relief of an IV dose. Sticking to the same opioid, no matter the route of administration, often decreases this behavior.
- The patient has been taking opioids frequently for a long time.
 - Many chronic pain patients take opioids for years without becoming addicted. Duration of use is not an indicator of addiction.
- The patient is a “clock watcher,” asking for the analgesics in advance of a specified time.
 - If the patient has noticed that the pain relief begins to wear off before the next dose, and they know that it will take up to 30 minutes to receive their next dose, they may begin to ask for it 30 minutes ahead of time. Controlled-release opioids and longer acting opioids tend to help this situation.
- The patient says that he/she is allergic to all but one opioid.
 - A true allergy to an opioid is rare. Usually the patient is referring to the side effects. If the side effects were unmanaged, the patient may believe they are allergic to it. Try to avoid using these medications unless they are indicated for a specific reason.

Managing Pain in a Drug-Dependent Patient

Assessment

How can we tell if it is addiction? A patient using an opioid to manage chronic pain uses the opioid as ordered and doesn't escalate doses. The opioid improves his or her quality of life by using the drug to control their pain. They know the risks and benefits of using opioids for pain control and accept responsibility. They do not request additional prescriptions for opioids or frequent dose increases, and they will work with the healthcare team to develop a treatment plan that works.

On the other hand, a patient with a substance abuse disorder cannot control his or her use of opioids and lets opioid use take precedence over family, friends, and work. He or she will let relationships with others deteriorate. They will continue to abuse opioids despite harm. The drug addict does not follow the requirements set forth by the healthcare team for the continuing use of opioids. They often "lose" prescriptions, repeatedly request refills before they should be needed, and demonstrate addictive behaviors such as injecting oral pain medications.

There is also a phenomenon known as **pseudoaddiction**. This occurs when patients with poorly controlled pain make attempts to obtain analgesia. This resembles drug seeking behavior and can be interpreted by medical staff as addictive behavior. This compromises pain management and undermines staff-patient trust. Pseudoaddiction is a very different theoretical construct from pain and addiction. *It will resolve when effective pain resolution is achieved.* A patient with poorly controlled pain may present as argumentative over their analgesics. They may have more frequent analgesic use and more frequent hospital admissions. These are acute behavioral pain-coping strategies. Someone who is truly addicted to their pain medication may turn to illicit drug use, may begin injecting their analgesics, or even use analgesics prescribed for someone else. These are passive/emotional pain-coping strategies. Differentiating between pseudoaddiction and true addiction is problematic and requires asking many questions.

To view a sample assessment tool, visit: http://www.bayrecovery.com/self_assess.html.

So What Are the Warning Signs of Addiction?

If your patient is obsessing about the medication (e.g., thinking about the pills, counting pills, worrying about running out, etc.), keeping a number of empty prescription bottles, seeing more than one doctor to obtain prescriptions, and/or filling prescriptions for the same drug at different pharmacies, he or she may be an addict. Other signs include taking the medication even after the symptoms have passed, lying about medications (e.g., how much is taken, what is being taken), and exaggerating symptoms to obtain more medication. These signs are often accompanied by significant behavioral changes such as changes in sleeping habits, appetite changes, substantial loss or gain of weight, withdrawal from family and friends, anger and shortness of temper, and a loss of interest in hobbies or leisure activities. This may lead to trouble at work, including tardiness, absenteeism, and poor performance, falling asleep in inappropriate places, appearing drowsy or tired on a consistent basis, and being secretive about their medications.

Is it safe for someone in recovery to take pain medication?

There are differing opinions about what is safe. Obviously, someone with a past history of drug addiction needs to be extra cautious when taking any form of a mood-altering medication. However, chronic pain management is possible while preventing addiction. Some people in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) still subscribe to the “Don’t Take Nothin’ No Matter What” theory. While this may be good advice for someone in recovery, when the word *nothin’* includes medication prescribed by a physician for a legitimate condition, those words can actually lead to a relapse. If someone is in pain, they may seek out alternative treatments that are not medically monitored. Both AA and NA mention that addicts should take care of medical issues outside the fellowship as noted in the Informational Pamphlet titled *In Times of Illness* (accessible from: http://www.na.org/pdf/litfiles/us_english/Booklet/In%20Times%20of%20Illness.pdf).

Pain Management While in Treatment

Pain specialists may treat a chronic pain patient currently enrolled in a narcotic treatment program with narcotics: The Controlled Substances Act does not set standards of medical practice. It is the responsibility of individual practitioners to treat patients according to their professional judgment for a legitimate medical purpose in accordance with generally acceptable medical standards. Although pain specialists may treat a chronic pain patient currently enrolled in a narcotic treatment program, they may only treat the patient's pain. Care of patients fighting substance abuse requires sensitivity to the issue and careful monitoring of outcomes. As a suggestion, you may wish to obtain the patient's permission to coordinate your pain management treatment with his or her narcotic treatment program.

Pain Management Post-Operatively

A patient who has a history of drug abuse or alcoholism, treated or untreated, will have a lower tolerance for pain post-operatively. They will need increased doses of pain medication to relieve their pain. Many addiction specialists recommend that bolus doses be given in addition to PCA pumps so that the additional pain can be addressed by the healthcare provider. Also, if the patient is not in recovery from their drug addiction or alcoholism, a withdrawal protocol should be initiated. The anxiety and pain associated with withdrawal will only exacerbate their pain and make it more difficult to control.

A patient being treated for chronic pain has an increased sensitivity to pain stimuli and a change in their drug metabolism (tolerance) that makes post-operative pain difficult to control. They will need larger doses of analgesics to manage their additional pain. The key is to get them back to their baseline of pain control and then add enough medication to cover the new pain.

Asking non-judgmental questions and using a multi-modal approach often works best for either type of drug-dependent patient. Getting a good history helps you to determine any needs they will have post-operatively. Remember, they metabolize drugs and process pain more quickly than patients who have not been taking opioids regularly.

Prevention

The best way to avoid a problem with prescription drugs is to use medications safely. This includes always following the directions carefully; do not take more *or less* without talking to the doctor. Patients should take medications only in the manner prescribed (e.g., sublingual, oral, IM, etc.). They should never crush or break the pills unless directed to do so by their physician. The patient needs to be clear about the drug's effects on driving and other daily tasks, as well as understand potential drug interactions with alcohol, food, or other drugs. For those patients in recovery from substance abuse, it is vital that they inform their doctor of past history of drug abuse. They need to be cautious of over-the-counter medications as some can cause a sense of euphoria if taken incorrectly.

Very often, chronic pain restricts sufferers' choices of friends, activities, lifestyle, and profession, which can make them feel as though they are not in control of their lives. Sometimes, the failure to control pain is seen as a "mental illness" - a brain being unable to deal with challenges that a body faces. That sense of helplessness and hopelessness can set up a relapse dynamic for someone already struggling to stay sober. Chronic pain sufferers need to be treated using a combination of medication, diet, counseling, and social network building skills.

Suggestions to Clients in Recovery

- Identify yourself as a recovering person to healthcare professionals.
- Talk to your doctor or pharmacist before taking over the counter drugs.
- Reach out to other members, ask for support.
- Work closely with your sponsor.
- Honestly evaluate your condition and explore alternatives to medication.
- Go to as many 12-step (AA/NA) meetings as possible:
 - <http://www.alcoholics-anonymous.org>
 - <http://www.na.org>
- Read 12-step literature.
- Write about your feelings.
- Practice the Twelve Steps and Twelve Traditions of AA or NA:
 - 12 Steps of AA http://www.alcoholics-anonymous.org/en_services_for_members.cfm?PageID=98&SubPage=117
 - 12 Traditions of AA http://www.alcoholics-anonymous.org/en_services_for_members.cfm?PageID=98&SubPage=116
 - 12 Steps of NA http://www.na.org/pdf/litfiles/us_english/misc/How%20it%20Works.pdf
 - 12 Traditions of NA http://www.na.org/pdf/litfiles/us_english/misc/Twelve%20traditions.pdf
- Arrange for an AA/NA member to be with you during surgery/emergency care.
- Pray and meditate.
- Share your thoughts and feelings honestly and openly.

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Managing Pain in a Drug-Dependent Patient

Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

1. The Joint Commission (formerly JCAHO) requires that all patients be afforded pain relief except:
 - A. Drug addicts
 - B. Alcoholics
 - C. Opiate addicts
 - D. None of the above

2. Pain is experienced in which realm:
 - A. Biological
 - B. Psychological
 - C. Social
 - D. All of the above

3. Which fibers are associated with acute pain?
 - A. $A\delta$ ("A-delta") fibers
 - B. C fibers
 - C. $A\beta$ ("A-beta") fibers
 - D. μ (*mu*) fibers

4. Which fibers are associated with chronic pain?
 - A. $A\delta$ ("A-delta") fibers
 - B. C fibers
 - C. $A\beta$ ("A-beta") fibers
 - D. μ (*mu*) fibers

5. Patients psychologically react to pain by thinking, feeling, and acting in certain ways.
 - A. True
 - B. False

6. In order to effectively assess pain, a nurse should only treat clients with the same culturally background.
 - A. True
 - B. False

Managing Pain in a Drug-Dependent Patient

7. Opioids activate which receptor:
- A. μ (*mu*)
 - B. κ (*kappa*)
 - C. δ (*delta*)
 - D. None of the above
8. The use of opioids causes pain relief but also several unpleasant side effects. Which one of the following is not a side effect of opioid medication?
- A. Miosis
 - B. Constipation
 - C. Agitation
 - D. Sedation
9. Chronic pain:
- A. Lasts longer than 6 months
 - B. Serves no useful purpose
 - C. Is difficult to treat
 - D. All of the above
10. Most people who use prescription drugs for non-medical purposes received their prescription from their physician.
- A. True
 - B. False
11. When a patient experiences nausea after discontinuing the use of an opioid, this is best described as an effect of:
- A. Tolerance
 - B. Physical Dependence
 - C. Addiction
 - D. Pseudoaddiction
12. Which of the following is not a symptom of opioid withdrawal?
- A. Constipation
 - B. Nausea
 - C. Bone pain
 - D. Involuntary leg movements
13. If a patient becomes physically dependent on a pain medication, they are not necessarily *addicted* to that drug.
- A. True
 - B. False
14. Pseudoaddiction will progress into drug addiction if not recognized early.
- A. True
 - B. False

15. Which one of the following is not a warning sign of addiction?
- A. Keeping more than one prescription bottle
 - B. Filling all their prescriptions at one pharmacy
 - C. Seeking prescriptions from more than one doctor
 - D. Taking medications after symptoms are gone
16. Compared to patients who are not taking opioids regularly, the opioid dependent patient post-operatively will need:
- A. No opioids
 - B. Less opioids
 - C. The same amount of opioids
 - D. More opioids
17. Which approach is most appropriate for a patient who is suffering from post-operative pain and chemical dependency?
- A. Avoid the drug that they have tolerance to
 - B. Use a multi-modal approach
 - C. Avoid all opioids
 - D. Ask the patient which drug they prefer
18. Chronic pain can lead to depression and a sense of isolation.
- A. True
 - B. False
19. Chronic pain patients should be treated using a combination of:
- A. Medication and lifestyle changes
 - B. Diet and exercise
 - C. Medication, diet, and counseling
 - D. Medication and meditation
20. A recovery person who is suffering from chronic pain should:
- A. Never disclose their recovery to their doctors
 - B. Try to control their intake of any drug prescribed for them
 - C. Not discuss their pain in 12 step meetings
 - D. None of the above